



Mental Health Care and Policy (In)justice in Ontario: Making Intersections Visible

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ABSTRACT *This paper applies an Intersectionality Based Policy Analysis Framework to Ontario's current mental health plan – The Roadmap: A Plan to Build Ontario's Mental Health and Addictions Services – in order to identify the contextual influences, underlying values and assumptions, which promote or undermine the uptake of human rights and equity as a mental health policy priority in Ontario. We found that dominant framings of the “problem” of mental health (as lack of access, coordination or integration, as a fiscal drain, as an economic burden, and as a clinical or medical problem) served to obscure and ignore the underlying social and structural conditions that impact mental health and the human rights violations that routinely occur in the context of “care.” We discuss the implications of The Roadmap ignoring social and structural determinants of health, and by way of contrast, explore how citizen engagement and activism can support rethinking mental health policy so that it is more just and equitable.*

KEYWORDS equity; mental health policy; human rights violations; managerialism; coercive practices; intersectionality-based policy analysis

Introduction

A key tension in mental health reform and policy development conversations is the pursuit of more just and equitable mental health services that meet people's needs, juxtaposed against mental health care systems that continue to enact discrimination and violate human rights. Human rights violations and coercive practices are mediated through day-to-day stigmatizing attitudes and discrimination alongside the use of legal mechanisms such as involuntary

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detainment and treatment that undermine choice and self-determination (Edan et al., 2019; Pūras, 2017). Populations worldwide who are marginalized through sexism, racism, colonization and citizenship status are disproportionately impacted by human rights violations often enacted through mental health services and policies that are presumably designed to support them (Burstow et al., 2014; Daley et al., 2019; Ibrahim, 2017; Kisely et al., 2020; Malcoe & Morrow, 2017).

Canada is no exception, because domestic mental health laws are not in line with the Charter of Rights and Freedoms or the United Nations (UN) Convention on the Rights of People with Disabilities (CRPD), allowing for the routine use of mental health practices such as seclusion, restraint, and detainment, that are often traumatizing for those on the receiving end (Pūras, 2017, 2018). Consequently, mental health services sometimes serve to perpetuate pre-cursors to mental distress such as social marginalization and exclusion rather than factors known to be supportive to mental health, like inclusiveness and support (Adelson, 2008; Brophy et al., 2006; Truth & Reconciliation Commission of Canada, 2015; Ussher, 2011). This point is highlighted by research that shows that the social context of people's lives is vital to their mental health (Malcoe & Morrow, 2017). That is, the social conditions in which people live drive relative social advantage and disadvantage. These disadvantages (and advantages) are not distributed equally; for example, in some jurisdictions racialized, migrant or Indigenous men are more likely to be subject to involuntary detainment and treatment as well as coercive practices like seclusion and restraints (physical and chemical) (Office of Health Equity & Anti-Black Racism & Mental Health Advisory Committee, 2021; Singh et al., 2007; Veen et al., 2018).

Critical health research has highlighted that values play an important role in how social problems are framed and subsequently addressed in policy and practice (Bacchi, 2012, 2016; Hankivsky, 2012; Varcoe et al., 2011). Evidence based policy paradigms have called for policy to be shaped by the best available scientific evidence, and yet we know that evidence is skewed towards the needs and wants of dominant groups in society. Thus, policy often misses or ignores the needs of marginalized and equity-seeking groups, because it is embedded in value systems that are responsible for creating and perpetuating ongoing social and structural inequities in society.

Western psychiatric and biomedical dominance globally, neoliberal policy regimes and the ongoing impact of colonization play significant roles in influencing policy and practice in mental health. Biomedical frameworks have been criticized for their reductionist approach to care, favouring individualized pharmaceutical solutions for mental distress rather than addressing complex social problems (Ibrahim, 2017; Mills, 2017).¹ Biomedicalism is reinforced

¹ A reductionist approach explains all social or cultural phenomena in biological terms. For example, mental health distress is reduced to a physical level where hormones, genes, neurochemicals, etc. are centered as the main cause and therefore the main site for treatment.

and sustained by neoliberal policy regimes that are heavily focused on balancing government budgets through the reduction of social spending and increasing health care system efficiency through the adoption of managerialism (Braedley & Luxton, 2010; Morrow, 2017).

In this paper we draw on critical mental health and mad studies frameworks in our application of an Intersectionality Based Policy Analysis Framework (IBPA) (Hankivsky, 2012) to identify contextual influences, including underlying values and assumptions, which promote or undermine the uptake of human rights and equity as a mental health policy priority in Ontario. Intersectionality is an activist, research and policy paradigm that highlights the ways in which oppression and privilege based on people's social positioning are inextricably linked, overlapping, and tied to how power is socially structured (Hill Collins & Bilge, 2016).

We begin by briefly tracing Ontario's mental health reform history and tracking key shifts in mental health policy and law. Then, through an analysis of Ontario's most recent mental health strategy, *A Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions Services* (hereafter called *The Roadmap*) (Ontario Ministry of Health and Long Term Care, 2020), we explore how dominant framings of the "problem" of mental health (as lack of access, coordination or integration, as a fiscal drain, as an economic burden, and as a clinical or medical problem) have served to obscure and virtually ignore the underlying social and structural conditions that impact mental health and the human rights violations that routinely occur in the context of "care." We highlight the connection between ignoring social and structural determinants of health and the related mental health burden experienced by people marginalized through things like citizenship status, sexism, racism, and colonization. The use of an intersectional analysis helps to make visible underlying power structures and the apparatus of managerialism in Ontario mental health policy and its function in masking the experiences of marginalized communities that disproportionately bear the burden of social inequities in Ontario.

We conclude by focusing in on the role of community-driven mental health initiatives in Toronto, Ontario, Canada, that are striving to address racism in mental health. We illustrate how activists demanding social justice in the wake of police murders of Black, Indigenous and People of Colour (BIPOC) can help shift policy agendas in relation to mental health crisis response. Our policy analysis contributes to an emerging body of work globally calling on policy makers to align their domestic mental health policies and practices with international commitments to upholding human rights and ensuring social justice in mental health via equity and rights oriented mental health services and policies (Stastny et al., 2020; World Health Organization, 2021).

Background

Ontario Mental Health Policy History

In identifying the contextual influences and underlying values and assumptions that promote or undermine the uptake of mental health, human rights, and equity as policy priorities, it is necessary to set the stage with some background on the Ontario mental health policy context. In this section we address developments both at the provincial level (Ontario) and at the municipal level (Toronto) that relate to the generation of the current mental health policy context.

Ontario deinstitutionalized people from large provincial psychiatric hospitals into communities throughout the 1970s and 80s (Moran & Wright, 2006). In the wake of deinstitutionalization successive governments produced mental health reform policies and strategies designed to build a system that would provide mental health and substance use care to people in the community (e.g., Heseltine, 1983; Ontario Ministry of Health, 1999; Ontario Ministry of Health, 2011; Provincial Community Mental Health Committee, 1988). Since 1983, each government strategy and plan has offered its own guidelines for system reform shaped both by party ideology and the nature of the consultations undertaken (Di Pierdomenico, 2016).

Notable themes over this time period include calls to reallocate funding percentages away from hospital-based care to community mental health care (Mental Health Commission of Canada, 2012; Ontario Ministry of Health, 1993, 1999, 2001; Provincial Health Services Restructuring Commission, 1999) affirmations of recovery based models of care and the engagement of people with lived experiences their family members and caregivers in the policy development process (Ontario Ministry of Health, 1993; Provincial Community Mental Health Committee, 1988; Select Committee on Mental Health and Addictions, 2010). In some of the more recent plans, the need to address the social determinants of mental health are raised, particularly the needs for housing, income support (Ontario Government, 2000; Provincial Forum of Mental Health Task Force Chairs, 2002) and services for youth and their families (Ontario Ministry of Health, 2011). As such, much of Ontario's mental health policy history has aligned with national directions (see Mental Health Commission of Canada, 2009, 2012) towards embracing recovery and human rights-aligned practice, potentially positioning the province as a leader in mental health and human rights. However, Ontario has not been able to successfully realize the necessary improvements to community-based services and supports which has resulted in increasing numbers of individuals in need of mental health care, social assistance, and housing coming in contact with emergency services, the police and the criminal justice system (Mack, 2014; Schmitt, 2023).

Major shifts in mental health law can be traced over a similar time, particularly with the introduction of Bill 68 (aka Brian's Law) (Bill C-68,

2000) which amended the Mental Health Act (2015) and the Health Care Consent Act (2023) and introduced Community Treatment Orders (CTOs). These legal changes were significant because CTOs are a mechanism which allows the state, using the enhanced powers of psychiatry, to control people's treatment in the community (Kaiser, 2009). A concomitant development was the establishment of the Ontario Patient Advocate Office (OPAC). The Office was meant to document human rights violations across the health care system and functioned to keep human rights and mental health on the political agenda. The OPAC was shut down only eight months after its formation, greatly weakening patient access to addressing human rights.

Lack of Policy Action Meeting Needs of Socially Marginalized Populations

As a focus on human rights has receded from mental health policy many of the mental health strategies put forward by Ontario focus more on system problems of integration and coordination of care (e.g., wait times and problems with access, the need for prevention and better funding) and indicate that successive recommendations for system change have gone unheeded (e.g., Select Committee on Mental Health & Addictions, 2010). Further, although Indigenous populations are occasionally singled out as needing specific kinds of supports, Ontario's mental health plans have rarely given very much focus and attention to the mental health inequities of populations marginalized through colonialism, racism, sexism, or poverty.

Also notably absent from mental health policy and law is an understanding of mental health that sees the biological as integrally interconnected with an individual's social, economic, and cultural context. For example, discussions of social determinants rarely go beyond the acknowledgement that housing and income are needed resources for mental health or that some populations (e.g., Indigenous or youth) are disproportionately impacted by mental health concerns and substance use. Secondly, the underlying structural and systemic problems related to the public health care system in Canada vis a vis the limitations of the *Canada Health Act* and public funding for mental health are rarely acknowledged as key governance challenges (Wiktorowicz et al., 2020). Additionally, human rights discussions are now virtually absent in Ontario policy, even though independent reports at the Federal level have raised concerns about mental health laws in Canada (Chammartin et al., 2011). Specifically, the lack of attention to coercive practices (seclusion & restraints) and the lack of a sustained dialogue on involuntary detainment and treatment in Ontario's *Mental Health Act* are problematic.

Ontario Health System Restructuring and Consolidation

Since the election of the Conservative Party in 2018, the Ontario government has been focused on the process of reorganizing the health care system. In this reorganization, the government has established the Mental Health and Addictions Centre of Excellence, which was first recommended by the Select Committee on Mental Health and Addictions (2010, p. 19). The Centre aims to establish a central point of accountability and oversight; create performance indicators and infrastructure to share evidence; standardize and monitor the quality and delivery of evidence-based services and clinical care; and provide support and resources to Ontario Health Teams. It is the mechanism for implementing Ontario's most recent strategic mental health plan: *The Roadmap* (Ontario Ministry of Health & Long Term Care, 2020).

Intersectionality as a Critical Mental Health Policy Analysis and Research Paradigm

In our analysis we employ the IBPA method, as outlined by Hankivsky (2012), in analyzing *The Roadmap* (Ontario Ministry of Health & Long Term Care, 2020) which is the current blueprint for mental health reform in the province. Additionally, we examine current City of Toronto documents related to policing and mental health, specifically, the *Toronto Police Service: Mental Health and Addictions Strategy* (Toronto Police Service, 2019) and *Rethinking Community Safety: A Step Forward for Toronto* (hereafter called *Rethinking Community Safety*) (Canadian Civil Liberties Association, 2020).

As a research and policy paradigm, intersectionality is increasingly being taken up across a wide range of disciplines to reveal the complex interactions among social categories of difference and the systems and processes of domination and oppression that produce experiences of privilege and disadvantage (Crenshaw, 1991; Hankivsky, 2012; Jordan-Zachery, 2019). IBPA is influenced by Bacchi's "What's the Problem Represented to Be?" (WPR) methodology (Bacchi, 2012, 2016) which is informed by the post-structural practice of "problematization." That is, complex social problems (i.e., homelessness, addiction, poverty, mental health, and distress) are not knowable outside of their broader social embeddedness and come to be represented and acted upon as problems in a variety of ways from different knowledge bases (i.e., policing, social work, psychology, public health, medicine) (Bacchi, 2016). IBPA builds on Bacchi's work by amplifying the social justice aims of the problematizing method and by introducing reflexive practice as a key component of the methodology (Hankivsky, 2012). In our work we used the descriptive questions as outlined in the IBPA methodology

to guide our analysis (Hankivsky, 2012).² These questions are designed to get at the values and assumptions that underlie the policy approach to a particular problem (including those of the analyst), and to understand how these problems or issues are conceptualized and subsequently addressed might impact different populations in unique and often oppressive ways.

Intersectionality aligns with a critical mental health approach and is well suited for exploring questions related to mental health equity and social justice because of the ways in which it reveals social and structural causes of inequities that underlie and even perpetuate mental health challenges (Morrow & Weisser, 2012; Redikopp, 2021; Rossiter & Morrow, 2011). Further, intersectionality and critical mental health approaches centre lived experiences and work towards social justice and human rights (e.g., MCSR Group, 2017). Flowing from this is the analytic potential to uncover complex relationships of power as they are experienced through a variety of interconnected systems and practices that confer privilege and disadvantage throughout society.

IBPA of Ontario's Road Map

In *The Roadmap* (Ontario Ministry of Health & Long Term Care, 2020) it quickly becomes apparent that managerialism is a key guiding ideology of the document. This is exemplified in the opening statements from the Premier, Minister of Health, and Associate Minister of Mental Health and Addictions, setting a tone that system management is what must be addressed (Ontario Ministry of Health & Long Term Care, 2020). Managerialism in this context is the domination of management practices in mental health. Managerialism, alongside of the adoption of private sector business practices in mental health care, has shifted welfare state concerns about people and the work of caring towards efficiencies, quality improvement, quantitatively measurable outcomes, and an over-riding focus on cost savings (Rankin & Campbell, 2006). For example, managerial accountability becomes fused with market accountability, leading to an over-riding preoccupation with system performance over innovation, collaboration, and democratic principles (Hoopee, 2003; Miller & McTavish, 2013).

The Roadmap emphasizes the need for immediate changes to mental health services to address long wait times, barriers to access, and uneven quality. To address these issues, it proposes four main areas of focus (four pillars): (1) improving quality, (2) expanding existing services, (3) implementing innovative solutions, and (4) improving access. Solutions addressing the

² Specifically, for the purposes of this analysis we focus on four descriptive questions found in IBPA: What is the policy problem under consideration?; How have representations of the problem come about?; How are groups differentially affected by this representation of the problem?; What are the current policy responses to the problem? (Hankivsky, 2012)

mental health of Ontario's population are thought to be found in reorganizing the current system to be more expansive, efficient, consistent, and accessible. As such, system or organizational issues related to mental health care delivery are prioritized.

Focusing on the first pillar, *improving quality: enhancing services across Ontario*, we see that *The Roadmap's* first order of business is to create a new core services framework that "will identify and define the core provincially-funded mental health and addictions services that will be made available over time to Ontarians regardless of where they live" (Ontario Ministry of Health & Long Term Care, 2020, p. 7). Here, improving quality is equated with ensuring that all Ontarians have clearly identified and defined mental health services available. Additionally, "core services standards... will also be developed to set expectations for providers on how each core service should be delivered... standards will be embedded in service provider accountability agreements and will drive quality improvement" (Ontario Ministry of Health & Long Term Care, 2020, p. 7). The language that stands out here is the focus on standardization of care through the implementation of service provider accountability agreements, a key managerial practice, to improve quality of care.

Additionally, *The Roadmap* states that it is "a plan built from the ground up" and based upon the findings that have flowed from discussions with Ontarians from various locales, communities, and organizations all around the province (Ontario Ministry of Health & Long Term Care, 2020, p. 5). However, it is striking that after a year-long process of consultations with hundreds of Ontarians, care providers, people with lived experiences, Indigenous communities, and municipalities from across the province, Ontario Health determined that the main problems that drive mental health issues can be solved by simply adjusting the amount of funds allocated to specific programs. Here, the focus on spending and rates of return on investments highlight the lack of nuance associated with the way the Ontario government understands issues of mental health.

The plan does highlight the need to invest in community-based mental health and addictions services and early intervention, and to build better data capacity, as the main takeaways from the consultation process (Ontario Ministry of Health & Long Term Care, 2020, p. 5). Although it is important that investment in mental health services is increased so that community need can be met, *The Roadmap's* emphasis on adopting an economic framing for mental health problems continually leads to technocratic solutions that focus on return on investment. For instance, *The Roadmap* frames mental health policy as primarily related to rates of return on spending and reduction in overuse of expensive services by focusing on questions such as: where should we direct mental health care dollars to ensure highest rates of return, and what is the best way to divert people away from more expensive and overburdened hospital mental health services? The solutions generated in *The Roadmap* are not wholly bad, from the perspective that increasing funding to areas that have

been historically underfunded is necessary (e.g., community care). However, the potential positive impact of this increase in funding is undermined through *The Roadmap's* managerial and technocratic approach to addressing mental health, where the focus is not on providing support for those in need but rather getting patients back to work and reining in social spending.

When a system's core values are tied to managerialism and fiscal concerns, the actual mental health needs of the population and the systemic factors (i.e., racism, colonialism, patriarchy, stigma, gendered-violence, over-surveillance, coercive-treatments) that underpin them are obscured. In effect, this occurs in *The Roadmap* as the use of a managerial frame decouples inequitable systems from the poor mental health outcomes they drive, often leading to a focus on individual responsibility and mentally healthy choices.

Managerialism Makes the Cause Invisible: Social Problems, Individual Responsibility

Managerialism in its pairing with neoliberal policy regimes in mental health serves to shore up individualistic understandings of complex social problems, which thus reduced, are thought to be manageable through technocratic arrangements. *The Roadmap* demonstrates this in its framing of mental health and addictions through a lens that seems to presume a biomedical cause, although conspicuously absent is any definition of mental health or substance use which are commonly referred to as “issues” or “challenges” (pp. 1, 4, 11, 12, 14, 17, 21) and occasionally as “illnesses” (pp. 3, 4, 18) throughout the document.

The Province's decision to model the new Mental Health and Addictions Centre of Excellence from Cancer Care Ontario is a clear example of where managerialism intersects with the framing of mental health and substance use solely as illnesses. This effectively reduces health policy responses to a series of performance metrics and indicators primarily related to health care use (e.g., emergency room visits, wait times for counselling, hospitalizations), which obscures the complexity of the human and social elements that we know underlie mental health. Further, the government is explicitly adopting the Canadian Institute of Health Information (CIHI) pan-Canadian mental health indicators. The CIHI indicators ignore how underlying social arrangements based on power impact mental health and shape both the experience of mental distress and the context of care for people based on their gender, race, ethnicity, ability and sexual orientation (Canadian Institutes for Health Information, n.d.).

For example, *The Roadmap* represents mental illness and addictions as problems that have an impact on quality of life and on other people, but special focus is given to the ways in which these problems reduce productivity of the individual and place a financial burden on the system:

With 500,000 Canadians per week calling in sick because of mental health and addictions issues, there are clear consequences for the province's economic productivity. By way of reference, the economic burden of mental health issues in Canada can be upwards of \$50 billion per year. (Ontario Ministry of Health & Long Term Care, 2020, p. 3)

Aside from linking mental health explicitly to economic aims of productivity (Rawson, 2021), the effect of this framing is to emphasize the individual and their burden on society while simultaneously legitimizing the back to work imperative. Further, centering economics functionally ignores the primary role that societal contexts play in either supporting or placing burdens on individuals' pursuit of mentally healthy lives. Describing individuals experiencing mental illness or distress as a societal burden is not only extremely stigmatizing, but this framing undermines the extensive body of work on the social determinants of mental health highlighting the primacy and pervasive influence social context have in determining healthy and unhealthy outcomes alike (Fisher & Baum, 2010; Labonté & Ruckert, 2015; Labonté & Schrecker, 2007; Marmot et al., 2012; Navarro, 2009; Paananen et al., 2013; Raphael, 2016; Wilkinson & Marmot, 2003; World Health Organization & Calouste Gulbenkian Foundation, 2014).

The Roadmap identifies the "needs of Ontario's diverse population" (Ontario Ministry of Health & Long Term Care, 2020, p. 4) as being important for a comprehensive mental health system, but diversity is understood only in terms of specific, supposedly discrete populations – the "Roadmap to Wellness will benefit all Ontarians, including children and youth, Indigenous people, Francophones, first responders, students, individuals who are justice-involved and people experiencing Homelessness" (p. 4). For example, Indigenous populations are seen as needing specialized mental health care responses – "in 2020, Ontario will continue to invest in additional resources to help expand access to services along the continuum of care, including culture-based services for Indigenous people, families and communities" (Ontario Ministry of Health & Long Term Care, 2020, p. 13), however there is no mention of the historical or continued impact of colonialism. Rather, the needs in Indigenous communities are seen as primarily "cultural." In terms of Indigenous mental health, singling out these populations as in need of culture-based services obfuscates the historical and ongoing impact of colonial violence in producing trauma, distress and a lack of general wellbeing in these communities, and has the effect of further stigmatizing Indigenous populations as, by their very nature, more prone to mental health problems.

When the government does see linkages between the social and structural determinants of mental health it does so only in the context of wanting to reduce the costs related to lost days at work. As such, the strategy introduces a pilot program designed specifically to support getting social assistance recipients experiencing depression and anxiety back to work:

Given the high prevalence of depression and anxiety among social assistance recipients, it is critical that mental health and addictions services and other programs such as employment supports will be closely aligned. Starting in 2020, this pilot program will provide direct access to publicly funded Ontario Structured Psychotherapy services to those on social assistance to support their return to work. (Ontario Ministry of Health & Long Term Care, 2020, p. 15)

These plans come with no acknowledgement of the province's low social assistance rates, high rates of poverty or of any acknowledgement of how income instability is connected to people's mental health. Instead, the story in *The Roadmap*, titled "Dan: A CBT Story,"³ illustrates the ways in which stress and anxiety are individualized to the point of ignoring their root causes. This story describes a truck driver who is increasingly under stress due to income insecurity, the needs of his son with a learning disability and the fact that his job takes him away from home for long hours (Ontario Ministry of Health & Long Term Care, 2020, p. 15). The story suggests that Dan's lack of capacity to cope with his stressful emotions is the main issue to be addressed. Thus, the story ends when Dan accesses an online resource for cognitive behavioural therapy (iCBT) that apparently helps him with his "negative" thoughts so that he can return to work worry-free.

The story of Dan exemplifies *The Roadmap's* focus on supporting individualized skill development related to coping with mental health challenges. The assumption is that now that Dan has gone through iCBT, he would be ready to go back to work, even though none of the social issues he is facing have been addressed (e.g., income insecurity, a son with learning challenges and precarious and long shift work).

Framing mental health and substance use as a problem of the individual ameliorated by technocratically expedient psychological or biomedical solutions serves to ignore the underlying social and structural conditions that drive and worsen mental illness.

Intersecting Structures of Marginalization and Mental Health Status

The adoption of the managerial frame that we see in *The Roadmap* assumes that any mental health equity issues within Ontario are due to previous government mismanagement rather than the lack of mental health policy that focuses on meeting the needs of populations that have experienced significant disadvantage and exposure to oppressive processes (racism, colonialism, patriarchy, stigma, gendered-violence, over-surveillance, coercive-treatments). Entirely invisible in the document are the lives of people of colour, Black communities, new immigrants, and refugees. Nor are there any discussions about the impact of gender oppression on women and transgender

³ CBT is an acronym for Cognitive Behavioural Therapy.

people or about the disproportionate mental health issues faced by members of the LGBTQ2S+ communities. The omission of specific and clear ways that this plan will support these overburdened, underserved, and often under resourced groups is particularly egregious given we know that race, ethnic background, immigration and refugee status factor strongly into mental health (Agić, 2015; Agić et al., 2016; Mental Health Commission of Canada, 2016). Further, immigrant, refugee, ethno-cultural and racialized populations experience more barriers to accessing the social resources needed to sustain mental wellness (e.g., housing, a living wage, challenges within the education system), not to mention the numerous barriers and discrimination they may face when accessing services (Agić, 2015; Agić et al., 2016; Mental Health Commission of Canada, 2016).

For instance, poor mental health is more likely to be reported by Black people in the Greater Toronto Area (GTA) than those who are not Black, while Black Ontarians province-wide are more likely than their white counterparts to come into contact with mental health care through police or emergency services (Office of Health Equity & the Anti-Black Racism & Mental Health Advisory Committee, 2021, p. 5). Additionally, analysis of data from The Centre for Addiction and Mental Health (CAMH), Canada's largest mental health and addictions teaching hospital, identified that Black patients had restraints used on them 44% more often than white patients (Office of Health Equity & the Anti-Black Racism & Mental Health Advisory Committee, 2021) and indicates that:

Reinforcing power structures have become embedded and reproduced in every facet of society and manifest in explicit and implicit forms of anti-Black racism that operate at individual, community and system levels... Anti-Black racism increased the risk of mental illness because Black populations are more likely to be exposed to negative social circumstances, which lead to stress. (p. 5)

This is a point that cannot be overstated, as racialized Ontarians experience notable inequities across social determinants of health such as income (one in four Black Ontarians is considered low income compared to one in seven of other racialized Ontarians),⁴ education (in the Toronto District School Board in 2011, white and racialized students are respectively 15% and 18% more likely to graduate than Black students), social exclusion (the Canadian prison population is disproportionately made up of Black Canadians), and food insecurity (compared to white households, Black households are more than three and half times more likely to be food insecure) (Office of Health Equity & the Anti-Black Racism & Mental Health Advisory Committee, 2021, p. 9). Our use of IBPA in its application to analyzing *The Roadmap* has revealed the ways in which the mental health system, when viewed solely as a problem of system efficiencies and operational problems, functions to obscure some of the root social and structural causes of mental distress and the fact that people's

⁴ I.e., people who identify as racialized but do not identify as Black.

experiences of mental distress are shaped by their social context. In so doing, the government can avoid the uncomfortable fact that its lack of support for the social welfare state and social policies like housing and income supports have contributed to the levels of mental distress it is purportedly trying to address through its strategy.

Catalyzing Change Through Activism

When it was first released, *The Roadmap* was not without criticism from advocacy organizations. Specifically, critics pointed to the fact that while the plan pledged new funds for mental health (in keeping with its fiscal narrative) it had previously cut provincial mental health funds by \$335 million in 2020 alone. This meant that provincial mental health spending would be a net negative when held up against the previous government's proposed budget (Smith, 2020). The funding promises do not make up the dollars cut, illustrating this government's priorities; they are more focused on reducing spending than engaging a meaningful process to meet the mental health needs of Ontarians (Smith, 2020). Additionally, it has been noted that much of the increased funding in *The Roadmap* was actually for police initiatives (Smith, 2020).

The latter is ironic given the ensuing activist demands emerging from the ongoing work of the Black Lives Matter movement, which has been calling to defund the police and for an end to police murders and related brutality against Black, Indigenous and people of colour. In the city of Toronto these demands took on direct relevance to mental health, and it is worth recounting how this activism has begun to shape mental health crisis response in the city for what it can illustrate about how problematizations influence policy responses.

In early 2021 a group of NGOs and community-based services in Toronto came together to redefine the narrative on community safety. In their report *Rethinking Community Safety* (Canadian Civil Liberties Association, 2020) the focus is on police racism and its impact in different domains, of which mental health is one. What is very clearly outlined in this plan is the way that systemic racism and discrimination play a central role in undermining community safety goals:

Addressing systemic discrimination and other issues with policing requires our ongoing, diligent, and dedicated efforts. The areas of activity outlined here provide an immediate opportunity to begin to move to models that better serve marginalized communities, reallocating resources to support vulnerable people, improve community safety, and produce better outcomes in the short and long term. (Canadian Civil Liberties Association, 2020, p. 23)

The report points to the ways in which policing functions to criminalize different intersections of identity, marginalization, poverty, and people

experiencing mental health crises. To make progress and address the impacts of systemic discrimination, it is necessary to reduce the role of police in mental health so that communities traditionally targeted by police can feel safer. Pathways to creating safer communities for overpoliced populations in Toronto are highlighted by the suggestions put forth in *Rethinking Community Safety* (Canadian Civil Liberties Association, 2020).

The proposed changes involve the reallocation of funds that at present are being used ineffectively within the policing and justice system to address community safety issues ranging from homelessness and mental health crisis response to the over policing of youth and gender-based violence. The report further called to expand already existing civilian-led crisis response programs in place of the \$150 million that the city spends on policing individuals experiencing mental health challenges (Canadian Civil Liberties Association, 2020, p. 12). It is argued that such an initiative can meet the needs of criminalized and socially marginalized individuals and their communities by proposing solutions that begin to address the social needs of these communities.

Ensuing from this collective activism has been a commitment at the municipal level to fund pilot projects on non-police crisis response which have the potential to radically re-shape the narrative around mental health crisis in its intersections with racism and policing as well as work to ensure those experiencing a crisis get proper care and support that prioritizes safety and wellbeing. In February 2021, the city council of Toronto approved the implementation of four such pilots called the Toronto Community Crisis Service (TCCS): three aimed at serving high priority areas of the city and one tailored to acknowledge the violent history of colonialism, policing, and intergenerational trauma experienced by the city's Indigenous communities (City of Toronto, 2021). The development of non-police crisis response in Toronto serves as a powerful illustrator of the very important role that grassroots movements have in shifting policy discourses and changing the framings of the problem to better align with the needs of the community. A six-month evaluation of the Toronto Community Crisis Service illustrated that crisis calls were being diverted from 911 to the new non-police mobile crisis teams, who are providing a range of on-site supports to people in crisis, including direct crisis care and facilitating access to services that can meet people's basic social needs (Provincial System Support Program & Shkaabe Makwa, 2023). In response to the positive evaluation, in 2023 the City of Toronto announced an expansion of the TCCS funding and services (City of Toronto, 2023).

The above example from the City of Toronto is a testament to the role that citizen activism can play in shaping policy responses to mental health. This work illustrates the impact that applying critical, intersectional, and social justice-based lenses can have in providing more meaningful foundations for understanding the underlying contexts that drive mental ill health and hinder the pursuit of wellbeing more broadly. Subsequently, very different solutions to the problem of community safety have emerged. In this case, the Toronto

Police Service's power was challenged through the thoughtful questioning of their role in undermining the safety and wellbeing of youth, women, Black, Indigenous, People of Colour (BIPOC), and people experiencing mental health issues.

Movements like this one are a reminder of how important it is to elevate and center social justice priorities within policy, and that many of the issues we aim to address arise, are produced, and reproduced because of existing social structures of oppression and marginalization. Further, it follows that at a minimum, any policy that aims to support mental health and wellbeing would need to align its solutions very clearly with commitments to addressing inequity, oppression, and trauma (historical and present) that flows from existing social systems and structures. Developments at the municipal level in Toronto remind us of what was lost in terms of opportunities at the provincial level in Ontario. Once positioned as a potential leader in mental health and human rights, in adopting a managerial and technocratic approach to mental health the Government of Ontario seems to have lost its ability (or desire) to respond to the needs of constituents who are the most marginalized and disproportionately experience mental health challenges.

Conclusion

Using IBPA, our analysis has surfaced the central emphasis put on managerialism to approach mental health care policy in Ontario. While managerialism prioritizes balancing government budgets, this comes at a cost. Reductions in social spending predictably translate into fewer mental health supports services offered and less access to those that remain available. The overly technocratic, biomedical, and economic frame used in *The Roadmap* to understand mental illness leaves little room for incorporating understandings related to the way that intersecting and disadvantaged social locations drive the social and structural inequities that often underlie mental health issues as well as access to mental health supports.

Thus, the proposal to improve population mental health through clinical and technical solutions and broadening access to already existing services and supports falls short of being able to fulsomely address mental health and wellbeing. The lack of importance attributed to these contextualizing factors in *The Roadmap* reinforces individualistic notions of mental health where the burden of responsibility is too often laid at the feet of those that are socially marginalized, criminalized and stigmatized for experiencing mental distress, violence, or trauma. Invariably, this has the greatest impact on individuals and communities that have been historically marginalized through interlocking and overlapping forms of oppression.

By way of contrast, in the example of the *Rethinking Community Safety* report, citizen engagement and activism can be a key catalyst for rethinking

mental health and the origins of mental distress as fundamentally tied to people's social and economic contexts. However, it remains to be seen whether this radical re-thinking of mental health and community safety can be sustained in the face of institutionalized biomedical and managerial dominance.

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References

- Adelson, N. (2008). Discourses of stress, social inequities, and the everyday worlds of First Nations women in a remote northern Canadian community. *Ethos*, 36(3), 316-333. <https://doi.org/10.1111/j.1548-1352.2008.00017.x>
- Agic, B. (2015). *Mental health of Canada's immigrants*. Centre for Addiction and Mental Health. http://olip-plio.ca/wp-content/uploads/2015/08/Immigrant-Mental-Health_June22_Branka-Agic1.pdf
- Agic, B., McKenzie, K., Tuck, A., & Antwi, M. (2016). *Supporting the mental health of refugees to Canada*. Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-01-25_refugee_mental_health_backgrounder_0.pdf
- Bacchi, C. (2012). Introducing the 'what's the problem represented to be?' approach. In A. Bletsas & C. Beasley (Eds.), *Engaging with Carol Bacchi: Strategic interventions and exchanges* (pp. 21-24). Cambridge University Press. <https://doi.org/10.1017/UPO9780987171856.003>
- Bacchi, C. (2016). Problematizations in health policy: Questioning how 'problems' are constituted in policies. *Sage Open*, 6(2). <https://doi.org/10.1177/2158244016653986>
- Bill C-68: *Brian's Law (Mental Health Legislative Reform)*. (2000). 1st Reading April 25, 2000, 37th Parliament. Retrieved from the Legislative Assembly of Ontario website: <https://www.ola.org/en/legislative-business/bills/parliament-37/session-1/bill-68>
- Braedley, S., & Luxton, M. (Eds.). (2010). *Neoliberalism and everyday life*. McGill-Queen's University Press.
- Brophy, L. M., Reece, J. E., & McDermott, F. (2006). A cluster analysis of people on community treatment orders in Victoria, Australia. *International Journal of Law and Psychiatry*, 29(6), 469-481. <https://doi.org/10.1016/j.ijlp.2006.07.001>
- Burstow, B., LeFrançois, B. A., & Diamond, S. (Eds.). (2014). *Psychiatry disrupted: Theorizing resistance and crafting the (r)evolution*. McGill-Queen's University Press.
- Canadian Civil Liberties Association. (2020). *Rethinking community safety*. <https://ccla.org/wp-content/uploads/2021/07/Rethinking-Community-Safety-A-Step-Forward-For-Toronto-Full-Report-12.pdf>
- Canadian Institutes for Health Information. (n.d.). *Wait times for community mental health counselling*. https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en&_ga=2.114249991.1250917516.1627930677-1899432952.1627930677#!/indicators/090/wait-times-for-community-mental-health-counselling;/mapC1;mapLevel2/
- Chammartin, N., Ogaranko, C., & Froese, B. (2011). *Equality, dignity and inclusion: Legislation that enhances human rights for people living with mental illness*. Evaluation Project Committee, Mental Health and the Law Advisory Committee, & Mental Health

- Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/Law_Evaluation_Project_Report_ENG_0.pdf
- City of Toronto. (2021, February 2). *City council unanimously approves community safety and crisis response pilots*. <https://www.toronto.ca/news/city-council-unanimously-approves-community-safety-and-crisis-response-pilots/>
- City of Toronto (2023, October 31). *City of Toronto Executive Committee adopts plan to expand Toronto Community Crisis Service citywide after successful first year*. <https://www.toronto.ca/news/city-of-toronto-executive-committee-adopts-plan-to-expand-toronto-community-crisis-service-citywide-after-successful-first-year/>
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299. <https://doi.org/10.2307/1229039>
- Daley, A., Costa, L., & Beresford, P. (Eds.). (2019). *Madness, violence, and power: A critical collection*. University of Toronto Press.
- Di Pierdomenico, K. (2016). *The state and community: Issues in mental health reform in Ontario* [Unpublished master's thesis]. York University.
- Edan, V., Brophy, L., Weller, P. J., Fossey, E., & Meadows, G. (2019). The experience of the use of community treatment orders following recovery-oriented practice training. *International Journal of Law and Psychiatry*, 64, 178-183. <https://doi.org/10/gscgv9>
- Fisher, M., & Baum, F. (2010). The social determinants of mental health: Implications for research and health promotion. *Australian & New Zealand Journal of Psychiatry*, 44(12), 1057-1063. <https://doi.org/10.3109/00048674.2010.509311>
- Hankivsky, O. (Ed.). (2012). *An intersectionality-based policy analysis framework*. SFU Institute for Intersectionality Research and Policy.
- Heseltine, G. F. (1983). *Towards a blueprint for change: A mental health policy and program perspective: Discussion paper*. Ontario Ministry of Health. <https://search.worldcat.org/title/Towards-a-blueprint-for-change:-a-mental-health-policy-and-program-perspective:-discussion-paper/oclc/456407303>
- Hill Collins, P., & Bilge, S. (2016). *Intersectionality*. Polity Press.
- Hoopee, J. (2003). Managerialism: Its history and dangers. *Historically Speaking*, 5(1), 6-8. <https://doi.org/10.1353/hsp.2003.0051>
- Ibrahim, M. (2017). Mental health in Africa: Human rights approaches to decolonization. In M. Morrow & L. H. Malcoe (Eds.), *Critical inquiries for social justice in mental health* (pp. 113-137). University of Toronto Press.
- Jordan-Zachery, J. S. (2019). Reflecting on am I a black woman or a woman who is black? A few thoughts on the meaning of intersectionality. In O. Hankivsky & J. S. Jordan-Zachery (Eds.), *The Palgrave handbook of intersectionality in public policy* (pp. 59-67). Springer International Publishing. https://doi.org/10.1007/978-3-319-98473-5_3
- Kaiser, H. A. (2009). Canadian mental health law: The slow process of redirecting the ship of state. *Health Law Journal*, 17, 139-194.
- Kisely, S., Moss, K., Boyd, M., & Siskind, D. (2020). Efficacy of compulsory community treatment and use in minority ethnic populations: A statewide cohort study. *Australian & New Zealand Journal of Psychiatry*, 54(1), 76-88.
- Labonté, R., & Ruckert, A. (2015). Social determinants of health under Canada's neo-liberal capture. In S. McBride, R. Mahon, & G. W. Boychuk (Eds.), *After '08: Social policy and the global financial crisis* (pp. 272-291). UBC Press.
- Labonté, R., & Schrecker, T. (2007). Globalization and social determinants of health: Introduction and methodological background (part 1 of 3). *Globalization and Health*, 3(1), 5. <https://doi.org/10.1186/1744-8603-3-5>
- Mack, T. (2014). The mad and the bad: The lethal use of force against mad people by Toronto police. *Critical Disability Discourses*, 6, 7-52. <https://cdd.journals.yorku.ca/index.php/cdd/article/view/39664>
- Malcoe, L. H., & Morrow, M. (2017). Introduction: Science, social (in) justice, and mental health. In M. Morrow & L. H. Malcoe (Eds.), *Critical inquiries for social justice in mental health* (pp. 3-30). University of Toronto Press.

- Marmot, M., Allen, J., Bell, R., Bloomer, E., & Goldblatt, P. (2012). WHO European review of social determinants of health and the health divide. *The Lancet*, 380(9846), 1011-1029. [https://doi.org/10.1016/S0140-6736\(12\)61228-8](https://doi.org/10.1016/S0140-6736(12)61228-8)
- MCSR Group. (2017). *Mad Canada shadow report: Reporting on human rights by the MCSR group to the Committee on the Rights of Persons with Disabilities in reference to the UN-CRPD*. https://e93deb58-4b7d-4f89-8706-2986d73eac24.filesusr.com/ugd/19da72_b6b3cfb350914a46b302c49f5ece1d6b.pdf
- Mental Health Commission of Canada. (2009). *Toward recovery & well-being: A framework for a mental-health strategy for Canada (504202013-001)* [Data set]. <https://doi.org/10.1037/e504202013-001>
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHStrategy_Strategy_ENG.pdf
- Mental Health Commission of Canada. (2016). *The case for diversity: Building the case to improve mental health services for immigrant, refugee, ethno-cultural and racialized populations*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-10/case_for_diversity_oct_2016_eng.pdf
- Miller, K. J., & McTavish, D. (2013). *Making and managing public policy*. Routledge.
- Mills, C. (2017). Global psychiatrization and psychic colonization: The coloniality of global mental health. In M. Morrow & L. H. Malcoe (Eds.), *Critical inquiries for social justice in mental health* (pp. 87-109). University of Toronto Press.
- Moran, J. E., & Wright, D. (2006). *Mental health and Canadian society: Historical perspectives* (Vol. 26). McGill-Queen's University Press.
- Morrow, M. (2017). Women and madness? revisited: The promise of intersectional and mad studies frameworks. In M. Morrow & L. H. Malcoe (Eds.), *Critical inquiries for social justice in mental health* (pp. 33-59). University of Toronto Press.
- Morrow, M., & Weisser, J. (2012). Towards a social justice framework of mental health recovery. *Studies in Social Justice*, 6(1), 27-43. <https://doi.org/10/gjjwdt>
- Navarro, V. (2009). What we mean by social determinants of health. *Global Health Promotion*, 16(1), 5-16. <https://doi.org/10.1177/1757975908100746>
- Office of Health Equity, & Anti-Black Racism & Mental Health Advisory Committee. (2021). *Dismantling anti-Black racism: A strategy of fair and just CAMH*. <https://www.camh.ca/-/media/files/camh-dismantling-anti-black-racism-pdf.pdf>
- Ontario Government. (2000). *Making it work: Policy framework for employment supports for people with serious mental illness*. <https://ontario.cmha.ca/wp-content/uploads/2016/08/makingitwork.pdf>
- Mental Health Act*, R.S.O., c.M.7, (2015). Retrieved from <https://www.ontario.ca/laws/statute/90m07>
- Health Care Consent Act*, S.O., c.2, Sched. A (2023). Retrieved from <https://www.ontario.ca/laws/statute/96h02>
- Ontario Ministry of Health. (1993). *Putting people first: The reform of mental health services in Ontario*. <https://ontario.cmha.ca/wp-content/uploads/2016/08/puttingpeoplefirst.pdf>
- Ontario Ministry of Health. (1999). *Making it happen: Implementation plan for mental health reform*. <https://ontario.cmha.ca/wp-content/uploads/2016/08/makingithappen1999.pdf>
- Ontario Ministry of Health. (2001). *Making it happen: Operational framework for the delivery of mental health services and supports*. <https://ontario.cmha.ca/wp-content/uploads/2016/08/makingithappen2001.pdf>
- Ontario Ministry of Health. (2011). *Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy*. https://www.opsba.org/wp-content/uploads/2021/02/Ontario_OpenMindsHealthyMinds_EN.pdf
- Ontario Ministry of Health and Long Term Care. (2020). *A roadmap to wellness: A plan to build Ontario's mental health and addictions services*. <https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system>
- Paananen, R., Ristikari, T., Merikukka, M., & Gissler, M. (2013). Social determinants of mental health: A Finnish nationwide follow-up study on mental disorders. *Journal of Epidemiol Community Health*, 67(12), 1025-1031. <https://doi.org/10.1136/jech-2013-202768>

- Provincial Community Mental Health Committee. (1988). *Building community support for people: A plan for mental health in Ontario*. <https://ontario.cmha.ca/wp-content/uploads/2016/08/grahamreport.pdf>
- Provincial Forum of Mental Health Task Force Chairs. (2002). *The time is now*.
- Provincial Health Services Restructuring Commission. (1999). *Building a community mental health system in Ontario: Report of the health services restructuring commission*.
- Provincial System Support Program & Shkaabe Makwa. (2023). *Toronto community crisis service: Six-month implementation evaluation report*. <https://www.toronto.ca/wp-content/uploads/2023/03/9034-APPENDIXEToronto-Community-Crisis-Service-Six-Month-Implementation-Evaluation-Report.pdf>
- Pūras, D. (2017). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. United Nations General Assembly. <https://reliefweb.int/sites/reliefweb.int/files/resources/G1707604.pdf>
- Pūras, D. (2018, November 16). *Preliminary observations—Country visit to Canada, 5 to 16 November 2018: UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* [Press release]. <https://www.ohchr.org/en/statements/2018/11/preliminary-observations-country-visit-canada-5-16-november-2018>
- Rankin, J. M., & Campbell, M. L. (2006). *Managing to nurse: Inside Canada's health care reform*. University of Toronto Press.
- Raphael, D. (Ed.). (2016). *Social determinants of health: Canadian perspectives* (2nd ed.). Canadian Scholars' Press Inc.
- Rawson, E. (2021). *Recovery as dispossession: An analysis of the economic case for mental health reform* [Unpublished master's thesis]. York University.
- Redikopp, S. (2021). Out of place, out of mind: Min(d)ing race in mad studies through a metaphor of spatiality. *Canadian Journal of Disability Studies*, 10(3), 96-118. <https://doi.org/10.15353/cjds.v10i3.817>
- Rossiter, K., & Morrow, M. (2011). Intersectional frameworks in mental health: Moving from theory to practice. In O. Hankivsky (Ed.), *Health inequities in Canada: Intersectional frameworks and practices* (pp. 312-330). UBC Press Vancouver.
- Schmitt, R. J. (2023). *Mental health crisis support rooted in community and human rights: A case study*. Human Rights Watch. https://www.hrw.org/sites/default/files/media_2023/11/drd1123_brochure_LOWRES_WEBSPREADS.pdf
- Select Committee on Mental Health and Addictions. (2010). *Navigating the journey to wellness: The comprehensive mental health and addictions action plan for Ontarians*. https://mdsc.ca/documents/Publications/Final%20Report_Select%20Report%20on%20Mental%20Health%20and%20Addict%20ENG%20Aug2010.pdf
- Singh, S. P., Greenwood, N. A. N., White, S., & Churchill, R. (2007). Ethnicity and the Mental Health Act 1983: Systematic review. *The British Journal of Psychiatry*, 191(2), 99-105. <https://doi.org/10.1192/bjp.bp.106.030346>
- Smith, P. (2020, March). *Ontario's 'roadmap to wellness' continues austerity for youth mental health services even as demand spikes*. World Socialist Web Site. <https://www.wsws.org/en/articles/2020/03/13/onyo-m13.html>
- Stastny, P., Lovell, A. M., Hannah, J., Goulart, D., Vasquez, A., O'Callaghan, S., & Pūras, D. (2020). Crisis response as a human rights flashpoint: Critical elements of community support for individuals experiencing significant emotional distress. *Health and Human Rights*, 22(1), 105-119.
- Toronto Police Service. (2019). *Mental health and addictions strategy*. https://www.tps.ca/media/filer_public/a7/4f/a74f6984-994c-49eb-a7a0-aa5a875bfb45/2bfd355e-fcea-4290-a26d-694303a3a515.pdf
- Truth & Reconciliation Commission of Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. https://irsi.ubc.ca/sites/default/files/inline-files/Executive_Summary_English_Web.pdf
- Ussher, J. M. (2011). *The madness of women: Myth and experience*. Routledge.

- Varcoe, C., Pauly, B., Laliberte, S., & MacPherson, G. (2011). Intersectionality, social justice and policy. In O. Hankivsky (ed.), *Intersectionality-Type Health Research in Canada* (pp. 331-348). UBC Press.
- Veen, C. V., Ibrahim, M., & Morrow, M. (2018). Dangerous discourses: Masculinity, coercion, and psychiatry. In J. M. Kilty & E. DeJ (Eds.), *Containing madness: Gender and "psy" in institutional contexts* (pp. 241-265). Springer International.
- Wiktorowicz, M. E., Di Pierdomenico, K., Buckley, N. J., Lurie, S., & Czucar, G. (2020). Governance of mental healthcare: Fragmented accountability. *Social Science & Medicine*, 256, 113007. <https://doi.org/10.1016/j.socscimed.2020.113007>
- Wilkinson, R. G., & Marmot, M. (2003). *Social determinants of health: The solid facts* (2nd ed.). World Health Organization.
<https://books.google.com/books?hl=en&lr=&id=QDFzqNZZHLMC&oi=fnd&pg=PA5&dq=sdoh+marmot&ots=xXnFjDWJpv&sig=Jg3nVMoGuvv2cCRriJn9jJY-3po>
- World Health Organization. (2021). *Guidance on community based mental health services: Promoting person centered and rights-based approaches*.
<https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services>
- World Health Organization & Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. <https://apps.who.int/iris/bitstream/handle/10665/112828/9789?sequence=1>